UKHealthCare

December 8, 2014

Diona Mullins, Policy Advisor
Office of Health Policy
Cabinet for Health & Family Services
275 E. Main Street, 4W-E
Frankfort, KY 40621

RE: CON Stakeholder Input

Dear Ms. Mullins,

This letter is in response to your October 8, 2014 request for stakeholder feedback regarding possible changes to the CON program that would further the implementation of specific core principles. UK HealthCare appreciates the opportunity to comment on potential Certificate of Need modernization efforts. We agree that modernization efforts may be beneficial in order to meet the Cabinet's primary vision of achieving the Triple Aim, as well as in many of the Cabinet's stated core principles. In order to better enable health care providers to work towards improving health for all Kentuckians, UK HealthCare suggests the following.

- ***Incentivizing Quality. Health care is rapidly moving toward adoption of objective quality metrics. Thus, the CON program will seek to support those providers that demonstrate attainment of robust quality indicators.***

  As evident in the Deloitte Workforce Study[1], as well as the Dan Sullivan CON Study commissioned by the Kentucky Hospital Association, a direct relationship exists between procedure volume and quality outcomes for certain specialty and tertiary services. Currently, CON applicants for the following services are required only to project their potential procedure/patient volume to document a need for their proposed service:

  - Neonatal intensive care units,
  - Open heart surgery programs,
  - Solid organ transplant programs.

  Once licensed, there is no state regulatory mechanism to ensure that those projected procedure/patient volumes are met, which may lead to potential quality issues. If market factors change, or there are unexpected workforce

[1] "The Commonwealth of Kentucky Health Care Facility Capacity Report," Deloitte, December 2013.

Office of the Executive Vice President for Health Affairs

University of Kentucky • 317 Wethington Building • 900 South Limestone • Lexington, Kentucky 40536-0200
Phone: 859-323-5126 • Fax: 859-323-1918 • ukhealthcare.uky.edu

challenges which prevent the facility from meeting their volume projections, the provider still maintains the licensure authority to continue providing these services. The State Health Plan[2] attempts to address this issue with respect to existing facilities with diagnostic cardiac catheterization services who propose to also provide primary and elective Percutaneous Coronary Intervention (PCI) services. Only upon successful completion of 2 year pilot program will the cabinet provide permanent licensure authority. This model holds providers responsible for maintaining standards of volume and quality, or risk revocation of their licensure authority to continue providing these services.

Although expansion of the pilot program process to other specialty and tertiary service lines would add to the administrative duties of the Cabinet, we feel it would be helpful in influencing and improving health outcomes for Kentuckians. While future applicants may be at a risk for losing their licensure authority to continue providing these services, we believe the overall effect of improved quality and health outcomes far outweighs the negatives.

- ***Improving Access to Care. For a number of reasons, Medicaid members have, on average, a more challenging path toward access to care. Thus, the CON program will seek to incorporate strategies that will incentivize greater access to care for Medicaid members, the newly insured and the remaining uninsured.***

  In many cases, the issue of access to care is not necessarily a function of inadequate volume or distribution of providers. With the recent Medicaid expansion, hundreds of thousands of Kentucky residents have become newly insured – many for the first time in their lives. These Kentuckians have traditionally obtained care in hospital emergency departments, instead of establishing a relationship with a primary care physician for their non-emergent medical needs and chronic disease management.

  Some of the Medicaid recipients present to our emergency department for non-emergent medical issues that could have been addressed by a primary care physician or an advanced practice registered nurse in a variety of settings such as a physician's office, an urgent treatment center, a primary care center, a rural health clinic or a limited services clinic. These non-emergent visits are unnecessarily raising health costs and placing an undue strain on our emergency departments. Many visits are also due to patients who may not be properly managing a chronic condition, such as diabetes, congestive heart failure or renal disease.

[2] "2013-2015 State Health Plan: Certificate of Need Review Standards," Prepared by Kentucky Cabinet for Health and Family Services, August 2013.

Due to the evolving insurance environment, it is our belief that enhancing educational funding and development/deployment of innovative strategies to improve both health and insurance literacy for the Medicaid population would improve their timely access to appropriate levels of care. Other state organizations, such as the Kentucky Health Benefit Exchange, have recently invested in educational outreach by deploying a physical location within Fayette Mall to assist the uninsured in enrolling for insurance coverage and educating consumers on what that coverage means.[3]

Governor Beshear's superutilizer initiative led by Commissioner Mayfield worked to identify Medicaid recipients who visited an emergency department at least 10 times during a calendar year as superutilizers.[4] This program provides individual education to those identified as superutilizers, and care teams were created to help educate those patients in a way that encourages proper emergency department utilization. Washington State provides another example of decreasing unnecessary utilization of their emergency departments with their "ER is for Emergencies" campaign.[5] Begun in 2012, House Bill 2127 required all Washington hospitals to implement the following seven best practices:

1. Track emergency department visits to avoid ED "shopping"
2. Implement patient education
3. Institute an extensive case management program
4. Reduce inappropriate ED visits by collaborative use of prompt visits to primary care physicians
5. Implement narcotic guidelines to discourage narcotic-seeking behavior
6. Track data on patients prescribed controlled substances
7. Track progress of the plan to make sure steps are working

As a result, the rate of emergency department visits declined by 9.9 percent, the rate of "frequent visitors" (five or more visits annually) dropped by 10.7 percent, the rate of visits resulting in a scheduled drug prescription fell by 24 percent and the rate of visits with a low-acuity (less serious) diagnosis decreased by 14.2 percent. In total, a savings of $33.65M was achieved through reductions to their Health Care Authority budget.

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[3] Meehan, Mary, "New Fayette Mall Store Offers Health Care Insurance Through Kynect," http://www.kentucky.com/2014/11/13/3536742_new-fayette-mall-store-offers.html?rh=1, November 2014.
[4] "Kentucky Taps HIE Data To Identify, Address Medicaid ED Super Users," iHealthBeat, http://www.ihealthbeat.org/articles/2014/4/24/kentucky-taps-hie-data-to-identify-address-medicaid-ed-super-users, April 2014.
[5] "Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation," A Report by the Washington State Health Care Authority, March 2014.

If the newly insured Medicaid population became aware of how to appropriately access the health care system the Commonwealth should benefit from better value, better care, and population health improvement.

Should educational initiatives be ineffective in directing some individuals to the appropriate settings to seek and obtain care, a next step may be for Medicaid to dis-incentivize unnecessary ED visits. An additional mechanism to encourage proper medical care utilization would be to increase copays for avoidable emergency department visits, once it is determined that the patient is aware of other care options and continues to visit the emergency department for non-emergent conditions. Although this strategy may be an unpopular choice, it would encourage Medicaid patients to become more selective regarding their treatment options and may lead to decreased health care costs while improving overall population health.

- ***Exempting Services for which CON is no longer necessary. Kentucky regulates via CON many services that even other CON states exempt. Thus, the Office of Health Policy will seek to focus on strategies to modernize Kentucky's CON program to be more reflective of modern healthcare trends.***

  KRS 216B.020 (2)(a) provides for an exemption from both CON and licensure for the private offices of physicians, dentists and other practitioners of the healing arts. This exemption has allowed physicians to establish multi-million dollar imaging centers and surgical facilities without benefit of either a CON or a license. In an attempt to address workforce shortages, the Commonwealth has expanded the scope of work for some mid-level practitioners such as physician assistants and advanced practice registered nurses but to date these types of professionals are unable to benefit from the "physician office exemption". In an attempt to improve access to care, amending KRS 216B.020 (1) to include CON exemptions for practice settings where these types of mid-level practitioners are providing services independently may prove beneficial in enhancing the continuum of care and relieving stresses placed upon over-burdened primary care physician offices and hospital emergency departments.

  Although a relatively new licensure category (902 KAR 20:400), limited service clinics provide quick, convenient access to care by a licensed advanced practice registered nurse for a variety of low acuity illnesses. The scope of services provided is especially limited, and when utilized appropriately, these facilities appear to be cost efficient alternatives to primary care physician appointments and emergency department encounters. For this reason, UK HealthCare recommends the Cabinet proposed legislation to amend KRS 216B.020 (1) to exempt limited service clinics from CON review.

In conclusion, it may be beneficial for the Cabinet to commission an independent study tasked with providing recommendations to modernize the CON program in an attempt to satisfy the triple aim. To our knowledge, the most recent research memorandum regarding CON was published in August 1989 by Karen Main at the request of the Interim Joint Committee on Health and Welfare. Although the Cabinet does frequently cite the recommendations and conclusions published in the Deloitte Workforce Analysis, it is our understanding and belief that their recommendations related to CON modernization are merely anecdotal and do not fully contemplate and/or comprehend the effect of drastically increasing the volume of providers upon our current health care delivery system. A more complete and thoughtful analysis of current health care financing and access trends would be desirable prior to any attempts to significantly alter the health care provider landscape.

Sincerely,

Mark D. Birdwhistell
Vice President for Administration and External Affairs